Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

LYNNETTE ORRICK DC
PRC HEALTH SERVICES LLC
6660 AIRLINE DR
HOUSTON TX 77076

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
AMERICAN CASUALTY CO

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-09-9806-01

MFDR Date Received
JUNE 26, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Our facility obtained pre-authorization for these services. In addition, Dr. Orrick is NOT in any Networks under PRC Health Srvcs. (tax id # 06-1837200). PRC Health Srvcs. is NOT affiliated w/her previous employer of Houston Spine & Rehab She has been employed w/PRC Health Srvcs. since 4/21/08."

Amount in Dispute: $1,830.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier has previously responded to this dispute on 08/05/2009. On October 26, 2009, Carrier issued additional payments. For services dates 2/5/2009 to 6/15/2009, Carrier issued a reimbursement of $3255.06. For service dates 10/8/2008 to 2/16/2009, Carrier issued a reimbursement of $1,857.93. Carrier asserts that no additional reimbursements are owed."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 13367, Austin, Tx /11

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 8, 2008 through November 3, 2008	Physical Therapy Services	$1,830.70	$1,678.39

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the procedures for reimbursement of professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 45 – Charges exceed your contract/legislated fee arrangement

- 663 – Reimbursement has been calculated according to the state fee schedule guidelines.
- PPN – Day Rate, Fee Schedule or UCR met.

Issues

1. Did the requestor have a contract with the insurance carrier?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – "Charges exceed your contract/legislated fee arrangement"; 663 – "Reimbursement has been calculated according to the state fee schedule guidelines"; and PNN – "Day Rate, Fee Schedule or UCR met." The requestor submitted a letter, to Medical Fee Dispute Resolution, with an e-mail from Debbie Malanka of National Choice Care stating, "I placed a call today to Houston Spine & Rehabilitation to confirm the merge and that PRC was affiliated with Houston Spine & Rehab. No. That was not the case. PRC purchased Houston Spine & Rehab's location at 800 Peakwood, Ste 3A and Dr. Orrick went to work for PRC…which is not an affiliate of Houston Spine and Rehab. Due to correspondence that NCC's staff received, it was misinterpretated [sic] by NCC's staff. Therefore, in summary….NCC has removed Dr. Orrick and PRC from it's system immediately, and it has been determined that NCC does not have a valid contract with PRC, tax id 061837200…" Therefore, the above denial/reduction reasons are not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

   28 Texas Administrative Code §134.203(c) states, in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications (1) … For surgery when performed in a facility setting, the established conversion factor to be applied is $66.32… (2) Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year." The MAR for the payable services may be calculated by (2008 TDI-DWC MEDICARE CONVERSION FACTOR) x Facility Price = MAR.

   - CPT Code 99212 – (52.83 ÷ 38.087) x $52.63 x 8 Units = $421.00 - $88.49 (insurance carrier payment) = $332.51.
   - CPT Code 97110 – (52.83 ÷ 38.087) x $38.19 x 23 Units = $878.28 - $300.39 (insurance carrier payment) = $577.99
   - CPT Code 97140 – (52.83 ÷ 38.087) x $35.37 x 16 Units = $565.93 - $216.74 (insurance carrier payment) = $349.14
   - CPT Code 97112 – (52.83 ÷ 38.087) x $39.62 x 8 Units = $316.92 - $52.79 (insurance carrier payment) = $264.13
   - CPT Code 97032-GP – (52.83 ÷ 38.087) x 22.01 x 8 Units = $176.10 - $21.48 (insurance carrier payment) = $154.62

2. Review of the submitted documentation finds that additional reimbursement is warranted.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,678.39.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,678.39 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 3, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.